

36
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

APR 17 1940

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

10785

Do not use this space.

1. PLACE OF DEATH

(a) County Dallas Registration District No. 251-341
(b) Township Benton Primary Registration District No. 5334
(c) City Buffalo or St. Registered No. 1237
(d) Street No. 2 (If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME

(a) Residence, No. Baby Howell St. 2
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M 4. COLOR OR RACE W 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Single
5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF
6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 1-8-1940
7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min. 2

OCCUPATION 8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc.
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation.

12. BIRTHPLACE (CITY OR TOWN) Dallas Co. (STATE OR COUNTRY) Mo.

FATHER 13. NAME Ray Howell

14. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY) Mo.

MOTHER 15. MAIDEN NAME Edith Patterson

16. BIRTHPLACE (CITY OR TOWN) Mo. (STATE OR COUNTRY) Mo.

17. INFORMANT Ray Howell (ADDRESS) Buffalo Mo.

18. BURIAL, CREMATION, OR REMOVAL PLACE Buffalo Mo. DATE 1-11-1940

19. FUNERAL DIRECTOR (NAME) H. B. Jones (ADDRESS) Buffalo Mo.

20. FILED 3-20-1940 Trammy Morrison Local Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 1-10-1940

22. I HEREBY CERTIFY, That I attended deceased from on 1-8-1940 to 1940, 1940

I last saw her alive on 1-8-1940 Death is said to have occurred on the date stated above, at 10:45 P.
The principal cause of death and related causes of importance were as follows:

Primature birth. Born at 5th month of pregnancy

Other contributory causes of importance: 159

Name of operation None Date of 10

What test confirmed diagnosis? None Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? None Date of injury 1940
Where did injury occur? None (Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.

Manner of injury None
Nature of injury None

24. Was disease or injury in any way related to occupation of deceased?
If so, specify None
(Signed) L. B. Jones, M. D.
(Address) Buffalo Mo.

RECEIVED
District Health Officer No. 7,
District File Number 4-42-382
Date Filed 4-1-46

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.